

ORDER FORM

Mail To:

STATE OF WISCONSIN
DEPARTMENT OF EMPLOYEE TRUST FUNDS
PO BOX 7931

INCOME CONTINUATION INSURANCE CLAIM PACKET

Check one:

- State Agency
 Local Government
Employer

Quantity wanted:

Employer Name _____ EIN 69-036- _____

Your Name _____ Title _____

Address _____ Phone # _____

City _____ State _____ Zip Code _____